2019 - 2020 Medication Authorization Form

Medication Authorization Form

Child's Name: ______________________________ Date of Birth: _____________________________

Name of Medication: ____

Reason for Medication: ____

Start Date: _________________________ Stop Date: _____________________________________

Time Given: ________________________ Amount Given: __________________________________

Frequency of medication delivery: ____

Possible Side Effects: ____

Instructions medication delivery (including oral, topical, other): _____________________________

____

Requires refrigeration? __________

Any other special instructions: ____

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Parent/Guardian Signature Date   Daytime Phone Number

____________________________________   ____________________________________

Physician Signature Date   Physician Phone Number

____________________________________   ____________________________________